RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

ENROLLMENT/CHANGE APPLICATION — LOCAL EDUCATION PLAN

State of Tennessee • Department of Finance and Administration • Division of Insurance Administration
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See back for complete instructions. You must sign and date this form, even if refusing coverage. Please print clearly.

PART 1 ENROLLMENT/CHANGE REQUEST — Check all that apply.

ADD
- ❑ New Eligible Employee
- ❑ Special Enrollment Provision
- ❑ Medical Underwriting
- ❑ Add Spouse
- ❑ Add Child(ren)
- ❑ Dental

Appointment Type: _____

Effective: _____

CHANGE
- ❑ Transfer Plans
- ❑ Change Name
- ❑ Change Address
- ❑ Marital Status
- ❑ Type of Coverage from _____ to _____
- ❑ Budget Code
- ❑ Appointment Type from _____ to _____

Effective: _____

TERMINATE/REASON
- ❑ Coverage: Self
- ❑ Coverage: Spouse
- ❑ Coverage: Child(ren)
- ❑ Dental
- ❑ Health
- ❑ Terminate employment
- ❑ Employee request
- ❑ Divorce
- ❑ Dependent age
- ❑ Dependent married
- ❑ Dependent no longer student
- ❑ Dependent no longer claimed on federal income tax
- ❑ Death

Date of Above Event: _____

PART 2 EMPLOYEE INFORMATION — Must be completed, even if refusing coverage.

Social Security No.	Last Name	First Name	Middle Initial

Street Address	Apt. #	City	State	Zip Code

County of Residence **Code** (see back)	County of Work **Code** (see back)			Birthdate
❑❑❑	❑❑❑	❑ Male ❑ Female	❑ Single ❑ Married ❑ Divorced ❑ Widowed	

Name of Employing Agency	Budget Code	Date Hired	Job Title

Is your spouse a participant in the State Group Insurance Program? ❑ Yes ❑ No If yes, complete the following:

Name	Social Security No.	Department/Agency Name

PART 3 ENROLLMENT INFORMATION

Health	Coverage Type	Dental Plan	Type of Dental Coverage
❑ PPO ❑ POS ❑ East* ❑ Middle ❑ West ❑ HMO* _____	❑ Single ❑ Family	❑ Prepaid Dental Plan* ❑ Preferred Dental Organization (PDO)	❑ Employee Only ❑ Employee+1 ❑ Employee+2 or more

* Additional form needed. Please contact your agency's insurance preparer.

PART 4 DEPENDENT INFORMATION — See back for definitions. Attach a separate sheet if necessary.

Social Security No.	Name Last, First, Mi	Birthdate MM/DD/YY	Relationship Code	Sex	Acquire Date	Student (age 19-24)	Coverage Health	Coverage Dental
				❑M ❑F		❑Y ❑N		
				❑M ❑F		❑Y ❑N		
				❑M ❑F		❑Y ❑N		
				❑M ❑F		❑Y ❑N		

PART 5 AUTHORIZATION

❑ **ACCEPT** I confirm that all of the information provided above is accurate. I understand that knowingly providing false and/or misleading information may subject me to disciplinary and/or legal action and may result in loss of insurance coverage. I authorize health care providers to furnish the insurance carrier with all medical, admission, and insurance records pertaining to me and my dependents. I understand that if my dependent(s) become ineligible for coverage that I must report the change to my insurance preparer within five working days. I understand that all claims paid for ineligible dependents will be recovered. As the policy holder, I am responsible for claims payments to my ineligible dependents.

❑ **REFUSAL** I have been given the opportunity by my employer to apply for the Group Insurance Program and after due consideration, have decided *not to take advantage of this offer*. I understand that if I later wish to apply, I or my dependents will have to provide proof of a special enrollment provision or prove insurable through medical underwriting.

I am currently enrolled in another health insurance plan: ❑ Yes ❑ No
A certificate of coverage letter must be provided to be exempt from the preexisting condition requirement.

I acknowledge receipt of my employee handbook and accept all the terms and conditions contained therein.

Employee Work Telephone	Employee Home Telephone
( )	( )
Signature	Date

INSTRUCTIONS

PART 1 ENROLLMENT/CHANGE REQUEST

Add: Check all appropriate boxes.

Change: Check desired change/enrollment with effective date.

Terminate: Check all coverages to be cancelled.

Reason: Check the appropriate reason. Coverage termination date is the last day of the month in which the event causing termination occurred.

NOTE: If completing the form for enrollment changes only (not a new enrollment), complete your name, social security number, employer, name and budget code. Then complete only the information you wish to change.

PART 2 EMPLOYEE INFORMATION

Complete each line in full. County Codes are listed below. If your spouse is covered through the State, Local Education, or Local Government Plan, please provide the requested information.

PART 3 ENROLLMENT INFORMATION

Health: The name of the HMO for which you are enrolling must be listed. If enrolling in a POS, check the box beside the appropriate service area. A physician selection card must be completed for options noted with an asterisk. Eligibility for an HMO or POS is based on your county of work or residence. These service areas are listed in the *Medical Plans Comparison Summary* brochure. If enrolling in the PPO or POS, a certificate of coverage letter must be provided to be exempt from the preexisting condition requirement.

Type of Coverage: Single covers employee only.
Family covers employee and all eligible dependents.

Dental: Optional dental coverage is only available if offered through your agency. Additional forms are required for the prepaid plan.

Anytime you elect to cover dependents, you must complete PART 4.

PART 4 DEPENDENT INFORMATION

Refer to your employee handbook for dependent eligibility rules. If you elect to cover dependents, you must provide all information requested in Part 4 for each dependent. You must provide a social security number for any dependent two years of age or older.

RELATIONSHIP CODES		ACQUIRE DATE
SP	Legally married spouse	Date of marriage
CN	Natural child	Date of birth
CN	Legally adopted child	Date of placement for adoption
CS	Stepchild for whom you or your spouse has legal or joint custody or shared parenting	Date custody obtained or marriage date
CL	Any child for whom you are the legal guardian	Date appointed guardian
CT	Any child you claim as a dependent for federal income tax.	Date you were able to claim child

IMPORTANT: It is your responsibility to notify your insurance preparer of any changes in the eligibility status of a dependent within five working days of becoming ineligible.

The following are *not eligible* for coverage as your dependent through the State Group Insurance Program:

- Ex-spouse (even if court ordered).
- Parents of the employee or spouse.
- Children in the armed forces on a full-time basis.
- Children over age 24 (unless they meet qualifications for incapacitation).
- Married children, regardless of age.
- Foster children.
- Live-in companions not legally married to the employee.

Acquire Dates are needed solely for the purposes of determining eligibility.

STUDENT: Check Yes or No for any unmarried dependent child older than 18 years and 11 months of age. A full-time student is one who is registered for at least the number of credit hours that the institution requires in its definition of full-time student status and who attends classes for two of three semesters or three of four quarters in any 12-month period.

COVERAGE HEALTH/DENTAL: Check block(s) to show coverage selected for each dependent.

PART 5 AUTHORIZATION

Check a block either accepting or refusing coverage. You must complete Parts 1, 2, and 5, even if refusing coverage. Sign and date the form.

COUNTY CODES

001	Anderson	017	Crockett	033	Hamilton	049	Lauderdale	065	Morgan	081	Stewart
002	Bedford	018	Cumberland	034	Hancock	050	Lawrence	066	Obion	082	Sullivan
003	Benton	019	Davidson	035	Hardeman	051	Lewis	067	Overton	083	Sumner
004	Bledsoe	020	Decatur	036	Hardin	052	Lincoln	068	Perry	084	Tipton
005	Blount	021	Dekalb	037	Hawkins	053	Loudon	069	Pickett	085	Trousdale
006	Bradley	022	Dickson	038	Haywood	054	McMinn	070	Polk	086	Unicoi
007	Campbell	023	Dyer	039	Henderson	055	McNairy	071	Putnam	087	Union
008	Cannon	024	Fayette	040	Henry	056	Macon	072	Rhea	088	Van Buren
009	Carroll	025	Fentress	041	Hickman	057	Madison	073	Roane	089	Warren
010	Carter	026	Franklin	042	Houston	058	Marion	074	Robertson	090	Washington
011	Cheatham	027	Gibson	043	Humphreys	059	Marshall	075	Rutherford	091	Wayne
012	Chester	028	Giles	044	Jackson	060	Maury	076	Scott	092	Weakley
013	Claiborne	029	Grainger	045	Jefferson	061	Meigs	077	Sequatchie	093	White
014	Clay	030	Greene	046	Johnson	062	Monroe	078	Sevier	094	Williamson
015	Cocke	031	Grundy	047	Knox	063	Montgomery	079	Shelby	095	Wilson
016	Coffee	032	Hamblen	048	Lake	064	Moore	080	Smith	096	Out of State